Gary Mendell, Testimony

Senator Gerratana, Representative Ritter and honorable members of the Public Health Committee.

My name is Gary Mendell and I am here to speak in full support of HB 6856, AN ACT CONCERNING SUBSTANCE ABUSE AND OPIOID OVERDOSE PREVENTION.

I was born and raised in CT, have lived my entire life here, and have raised my family here.

Like many people living in CT, I too have a personal connection to the impact that the addiction to prescription painkillers can have on a family, and a life. I am a father who had to bury his first born son. My son Brian was 25 years old when he died.

In the months following Brian's death, I left my 25-year career in business and dedicated the rest of my life to sparing other families from the unspeakable tragedy my family has endured. I founded a national organization, Shatterproof, in part to protect our loved ones through commonsense changes in state level public policies. Our organization has assembled a scientific committee with many of the leading experts in this field, and are up to date on all current evidence based research. We have recently worked with legislators to help pass legislation in DE, PA and WV, and are currently working in KY and FL, and would like to be helpful here in my home state of Connecticut.

Deaths from drug overdose have been rising steadily over the past two decades and have become the leading cause of injury death in the United States:

- In the last 15 years, deaths from prescription opioid pain relievers (such as oxycodone, hydrocodone, methadone, or fentanyl) have quadrupled, killing more than 16,000 people in the United States in 2013.
- Much of this has been attributed to the substantial increase in the prescription of opioids.

- In the last 10 years, the amount of opioids prescribed and sold in the U.S. quadrupled, yet there has not been an overall change in the amount of pain that Americans report.

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- In 2012, health care providers wrote 259 million prescriptions for opioids —enough for every American adult to have a bottle of pills.

- Overdose rates are higher in states where opioids are prescribed more frequently.

    - Every day in the US, 114 people die of a drug overdose and another 6,748 are treated in emergency departments for the misuse or abuse of drugs. The CDC reports that 8,257 people died of heroin-related deaths in 2013, 39% more than in 2012.

Connecticut is no different. In 2014, 307 of our loved ones died of an overdose caused by either prescription painkillers or heroin. That number has grown from 257 in 2013 and 174 in 2012. This tragedy touches suburban and rural communities alike and is having devastating effects on all segments of our population - teenagers, working professionals and grandparents have all overdosed in the past year.

Connecticut legislators have already taken important steps to protect our loved ones from this epidemic in legislation passed in 2012 and 2014. In fact, CT state police have saved the life of 20 people since they started carry naloxone last October.

But more can and must be done.

And HB 6856, AN ACT CONCERNING SUBSTANCE ABUSE AND OPIOID OVERDOSE PREVENTION does just that. I will address 3 of its critical elements, each of which will save the lives of many of our sons and daughters.

1. Many states, including Connecticut, permit prescribers acting with reasonable care to prescribe and dispense naloxone to treat or prevent an opioid overdose, and provides immunity from civil or criminal liability for that action. Many states also permit individuals acting with reasonable care to administer naloxone in the event of a drug overdose, and provides them with civil or criminal immunity.

   However, many people are unable to visit a physician or other prescriber to get a prescription for naloxone. For this reason, expanding access to naloxone through pharmacies has become a key priority nationwide. Both the American Pharmacists Association and the National Association of Boards of Pharmacy support naloxone distribution through pharmacies. In addition seven states, including NY, MA, VT and RI have recently changed laws or regulations to explicitly permit pharmacists to dispense naloxone without the patient first being seen by a prescriber.

   Pharmacists are highly trained medical professionals who are consistently ranked as one of the most trusted members of the health care team. They are experts at identifying medication-related risk, including that caused by high doses of opioids and opioids in combination with other medications.

In the past few years I have heard the same story time and time again: "*If only someone with my son or daughter had naloxone at the time of their overdose, might still be alive today.*"

HB 6856 permits pharmacists to identify patients who may be at risk of overdose, counsel them regarding overdose prevention, and prescribe and dispense naloxone as medically appropriate would absolutely improve access to this lifesaving medication.

2. Prescription monitoring programs (PMPs) are state databases that collect information on controlled substance prescriptions, store that information securely, and make it available only to certain individuals and in circumstances.

   By providing medical professionals with information regarding the medications their patients are receiving, they may reduce the risk of inadvertent prescription of medications at doses or in combinations that may put those patients at risk of overdose.[i] They can also assist medical practitioners to identify patients who may benefit from screening for substance abuse treatment or referral to a pain management specialist, and provide actionable data on opioid prescribing trends to public health officials and policymakers.[ii] They can also help identify practitioners who may be acting unethically or illegally, such as the small number of physicians who have operated "pill mills" that indiscriminately prescribe medications to patients without medical justification.[iii]

   Data suggest that the use of PMPs may result in improved clinical decision-making, including more appropriate treatment and better health outcomes.

   Recent surveys in Rhode Island, Oregon and Connecticut, suggest prescribers who used the PMP were more likely to adequately respond to suspected drug abuse, including referrals for substance abuse treatment. There is also evidence that states with PMPs have slower growth in the availability of prescription pain relievers than states without PMPs.[iv]

   The CDC recommends that information be reported immediately upon dispensing. 16 states already require pharmacies to report information within 24 hours. One state, OK, requires reports in real time. **HB 6856 requires reporting in 24 hours.**

   35 states also permit licensed health care professionals acting as the authorized agent of a practitioner to access PMP data. **HB 6856 provides for this.**

   And the CDC also recommends that all prescribers be required to access the PMP before writing a prescription and at certain intervals thereafter. Six states, including NY require this. Nineteen states, including MA, NY, RI, VT, require prescribers to access the PMP under certain circumstances. **HB 6856 includes this requirement.**

3. Most medical professionals receive little training on pain management, opioid

prescribing, and substance abuse prevention. In a recent study of 104 American medical schools, only 4 reported having a required pain course.

In a recent study of practicing primary care physicians, over 47% reported that their medical education and training was unsatisfactory in preparing them to address opioid dependence, and 40% reported that it was unsatisfactory in preparing them to address chronic pain.[v] Fewer than 20% of primary care physicians in a recent survey reported being "very prepared" to identify alcohol or drug dependence.

This lack of training in the prevention, diagnosis, and treatment of drug-related medical conditions has been known for decades, but little has been done to address it.

Improving physician education in the areas of appropriate prescribing and effective response to substance use disorder has been identified as a priority for the profession.[vi] Continuing Medical Education (CME) has been shown to help providers "feel confident in implementing the appropriate intervention,"[vii] and a study of physicians found that the number of hours of CME received was a key factor in their willingness to treat substance use disorder.[viii]

Based on the current lack of training in the prevention, diagnosis, and treatment of drug-related medical conditions and the widely recognized importance of improving physician education in the areas of appropriate prescribing and effective response to substance use disorder, all licensed Connecticut physicians, advanced practice registered nurses, dentists and physician assistants should receive education in the best practices of prescribing controlled substances every two years. **HB 6856 provides for this.**

As of October 2014, at least thirteen states require that physicians obtain CME in pain management or controlled substance prescribing.[ix] Massachusetts requires that physicians obtain 3 credits in pain management every three years, while West Virginia requires 3 hours of drug diversion training, best-practice prescribing of controlled substances training and training on prescribing and administration of an opioid antagonist. States with similar requirements include California, Florida, Iowa, Kentucky, New Mexico, Oregon, Rhode Island, South Carolina, Tennessee, Texas, and Vermont. Additionally, several state legislatures, including New York and Georgia, recently introduced bills that would enact more extensive CME requirements. Georgia's proposal would require physicians to complete at least 5 hours of CME every 2 years on the prescription and use of controlled substances and "the risks and indicators regarding development of addiction to controlled substances."[x]

In closing, I would just like to say, that since my son passed away just over three years ago, I wake up every morning knowing what I cannot change. My son will not be coming home.

But I also wake up knowing what we can change.

Today this committee can move this bill forward, in its current form, and substantially reduce the enormous loss of life due to an overdose in Connecticut.

Thank you for your time, happy to answer questions.

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[i] Perrone J, Nelson LS. Medication reconciliation for controlled substances--an "ideal" prescription-drug monitoring program. N Engl J Med 2012;366(25):2341-3.

[ii] Katz N, Panas L, Kim M, Audet AD, Bilansky A, Eadie J, et al. Usefulness of prescription monitoring programs for surveillance--analysis of Schedule II opioid prescription data in Massachusetts, 1996-2006. Pharmacoepidemiology and drug safety 2010;19(2):115-23.

[iii] Delcher C, Wagenaar AC, Goldberger BA, Cook RL, Maldonado-Molina MM. Abrupt decline in oxycodone-caused mortality after implementation of Florida's Prescription Drug Monitoring Program. Drug Alcohol Depend 2015.

[iv] 6 Simeone, R. and Holland, L. "An evaluation of prescription drug monitoring programs," Simeone Associates, Inc., 2006, http://www.simeoneassociates.com/simeone3.pdf. See also "State prescription monitoring programs highly effective," Carnevale Associates, 2007, http://www.pdmpexcellence.org/pdfs/pdmp_info_brief2.pdf; Reisman R.M., Shenoy P.J., Atherly A.J., Flowers C.R. Prescription opioid usage and abuse relationships: An evaluation of state prescription drug monitoring efficacy. Substance Abuse: Research and Treatment. 2009;3:41-51. http://www.la-press.com/prescription-opioid-usage-and-abuse-relationships-an-evaluation-of-sta-article-a1442

[v] Keller CE, Ashrafioun L, Neumann AM, Van Klein J, Fox CH, Blondell RD. Practices, perceptions, and concerns of primary care physicians about opioid dependence associated with the treatment of chronic pain. Subst Abus. 2012;33(2):103–113.

[vi] Wyatt SA, Dekker MA. Improving physician and medical student education in substance use disorders. *J Am Osteopath Assoc*. 2007:107:ES27-38; O'Connor PG, Nyquist JG, McLellan AT. Integrating Addiction Medicine Into Graduate Medical Education in Primary Care: The Time Has Come. Ann Intern Med. 2011;154:56-59.

[vii] *See* Miller et al., *supra* note 8.

[viii] *Id.*

[ix] Federation of State Medical Boards, Continuing Medical Education: Board-by-Board Overview, *available at http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/GRPOL_CME_Overview_by_State.pdf.* Accessed March 10, 2015.

[x] Georgia HB 564, Session 2015-2016, *available at http://www.legis.ga.gov/Legislation/20152016/150320.pdf.* Accessed March 10, 2015.

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